Virginia Pre-Exposure Prophylaxis Drug Assistance Program
(VA PrEP DAP) C O NFIDENTIAL APPLICATION

☐ **APPROVED**

SECTION 1: APPLICANT INFORMATION

Must Provide Proof of Legal Name

Legal Last Name: _____ **Legal First Name:**_____ **MI:**_____

Preferred name (if different than legal name):_____

Date of Birth: ____/____/_____ **Email:** _____
MM DD YYYY

Assigned Sex at Birth: □ male □ female

Current Gender Identity: □ male □ female □ transgender(male to female) □ transgender (female to male)
□ transgender-unspecified: _____

Pronoun (optional): □ he/him □ she/her □they/they

Home Address If you have a home address, complete the address field below. **Must Provide Proof of Virginia Residency**
If you do not have a home address, complete the **No Home Address Declaration.** **PO Boxes cannot be accepted**

Address:_____ **Apartment/Unit #:** _____

City:_____ **State:** ___ **ZIP:** _____

No Home Address Declaration If you do not have a home address complete the following statement:
I do not have a home address. Last night I stayed (circle):
□at a park □in a car □ at a shelter □on the street □with family/friends □somewhere else

In the city of:_____

Mailing Address Same as my home address above: □ Yes □ No **If no**, please provide a physical address below.
PO Boxes cannot be accepted

Address:_____ **Apartment/Unit #:** _____

City:_____ **State:** VA **ZIP:** _____

Primary Phone: (___)_____-_____ **May we leave a voicemail?** □ Yes □ No

¿Quisiera usted recibir documentos de nosotros en español?
Would you like to receive documents from us in Spanish? □ Sí □ No

Race (Check all that apply)
□ Asian
□ Black/African American
□ White/Caucasian
□ Alaska Native/American Indian
□ Native Hawaiian/Pacific Islander
□ Other, specify:_____

Ethnicity (Check One):
□ Hispanic/Latino(a)
□ Non-Hispanic/Latino(a)

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Health Insurance and Medical History

Do you currently have any type of health insurance? □ Yes □ No
If yes, does your insurance provide prescription drug coverage? □ Yes □ No

Prior to today, have you ever been diagnosed with (check all that apply):
□ Syphilis □ Gonorrhea □ Chlamydia
If you checked any of the boxes above, were you diagnosed with these in the last year? □ Yes □ No

Have you ever used any of the following substances (check all that apply):
- □ Alcohol (ex. beer, wine, liquor)
- □Amphetamines (ex. meth, speed, non- prescription use of Adderall)
- □ Cocaine or crack-cocaine
- □ MDMA (ex. molly, ecstasy)
- □ Hallucinogens (ex. LSD, acid, mushrooms)
- □ GHB
- □ Marijuana (ex. joints, blunts, edibles)
- □ Opiates (ex. heroin, Fentanyl, OxyContin or Morphine)

Have you ever injected any of the following substances (check all that apply):
- □Amphetamines (ex. meth, speed, non-prescription use of Adderall)
- □ Cocaine or crack-cocaine
- □ Opiates (ex. heroin, Fentanyl, OxyContin or Morphine)
- □ Injected other substance, specify: _____

Please check ALL risk categories that apply to you: in the last year
- □ Man who has sex with men and engages in unprotected anal intercourse
- □ Diagnosed with a Sexually Transmitted Infection (example: syphilis, gonorrhea, chlamydia)
- □ Exposure to an STI through a sexual network
- □ Ten or more sexual partners
- □ Injection drug user who has shared injection drug equipment and/ or injected one or more times a day and/or injected methamphetamines and/or engaged in high risk sexual behavior
- □ Have had unprotected anal intercourse with a partner of unknown HIV-1 status with any of the factors listed above
- □ Engaged in transactional sex (sex for money, drugs, gifts, etc)
- □ Engage in high risk sexual behaviors with known HIV-infected partner

What is your annual income from all sources? $_____

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Authorized Representative
Please provide the following information for any family/friends you would like us to be able to talk to about your PrEP DAP

First and Last Name:_____

Primary Phone Number: _____ **Email:**_____

Date of Birth: _____/_____/_____
MM DD YYYY

Eligibility, Agreement, Release of Information, & Assignment of Benefits

CONSENT and Signature

I understand that this is a pilot program and funding may not be available after 1 year. The continuation of this program depends on the availability of funds. I understand it is my responsibility to provide medical status and proof of income every 12 months. I further understand it is my responsibility to notify VDH of any changes in my contact information, income or insurance status (if applicable). Failure to provide the necessary documentation could jeopardize my approved assistance through the Virginia Department of Health.

My information is being entered into a statewide database by the Virginia Department of Health. VDH agrees to treat all information as confidential. I hereby give my consent to VDH to obtain, verify, and/or release my demographic, medical, prescription, and/or insurance coverage information, with other entities as necessary to effectively determine financial eligibility and manage my medication access. Information may be shared with but is not limited to the following: physician, health department personnel, other Division of Disease Prevention programs (including Surveillance, Care and Prevention), treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier. VDH agrees to treat any and all such information as confidential.

I understand that this consent will remain in effect as long as my dependent or I remain on PrEP DAP or until I withdraw it.

I have read, understand and agree to the above Client Responsibilities and Release of Consent. I verify that the information provided in this application is complete and accurate to the best of my knowledge.

_____ _____
Signature of Client, Parent/Legal Guardian or Person acting in Loco Parentis Date Signed

_____
Relationship (If signature is not of Client)

_____ _____
Signature of Person Obtaining Consent Date Signed

Please provide the information below if a friend, family member or advocate helped to complete this application:

First Name	MI	Last Name
Address		
City	State	Zip
Phone Number		

In order to process your application in a timely manner it is important that the application is complete. If your application is not complete, we will not be able to process your application and there may be a delay in obtaining your medication.

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-864-VDH (TDD/TTY call 711).

Checklist for Submitting a Complete PrEP DAP Application:

☐ Proof of Legal Name (New PrEP DAP Applicants Only)

Please provide us a copy of one of the following to verify your full legal name:

- Any state driver's license or identification card
- Passport

☐ Proof of VA Residency

Please provide us a copy of one of the following to verify your VA residency:

- Current Virginia State driver's license or identification card
- Virginia voter registration card
- Utility bill (cell phone bills are not accepted)
- Lease/rental/mortgage agreement

☐ Proof of Income

Please provide us a copy of one of the following to verify your proof of income:

- Copies of three most recent, consecutive pay stubs that show group income and payroll deductions complete copy of most recent Federal Income tax return
- Veteran's or other retirement benefits (a copy of award letter or any other official documentation showing the amount received on a regular basis)
- Government benefits and/or award (such as Social Security and unemployment benefits)

☐ Proof of No Income

Please provide us a copy of one of the following to verify no income proof:

- Termination or layoff notice from most recent employer on company letterhead
- A "proof of no income" letter that identifies the source of the applicant's food and shelter (letter signed by agency, shelter, relative, friend, or some other non-agency source of support)

☐ Insurance Card

If you have insurance, please provide us a copy of your insurance card.

☐ Application completed in pen

☐ Application filled out completely (both Section 1 & Section 2) with all required documentation, dates and signatures

SECTION 2: HIV & HEALTH STATUS INFORMATION

We must confirm your HIV and health status in order to process your application. This section must be completed by you **and** your health care provider. Please submit this form to us with this application or ask your health care provider to send it directly by mail or fax. You can call us at 804-864-7938 if you have questions about this form.

Client Section – To Be Completed By The Client

I authorize my health care provider to release the information on this form to the Virginia State Department of Health.

Full Legal Name _____ Date of Birth _____
(MM/DD/YYYY)

_____ _____
Applicant or Legal Guardian Signature **(Do Not Leave Blank)** Today's Date (MM/DD/YYYY) **(Do Not Leave Blank)**

Health Care Provider Section – To Be Completed By The Health Care Provider □ 340b

Is this patient HIV negative? □ Yes □ No **Date of last negative HIV test:** ____/_____/_____
MM DD YYYY

Name of health department or clinic for medication pick-up:_____

Address:_____

City: _____ **State:** VA **ZIP:** _____

By signing below, you:

- Confirm that you have evidence of the patient's HIV status and risk.
- Certify the information on this form is accurate and complete to the best of your knowledge.

_____ _____
Health Care Provider Signature **(Do Not Leave Blank)** Today's Date (mm/dd/yyyy) **(Do Not Leave Blank)**

_____
Health Care Provider – Print First & Last Name

Send to: ATTN: DDP at PO Box 2448, Richmond, VA, 23218-2448 or Fax #: 804-864-8053